

Identifying the prevalence of aggressive behaviour reported by Registered Intellectual Disability Nurses in residential intellectual disability services: an Irish perspective.

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Abstract

Purpose – Despite the high incidence of aggressive behaviours among some individuals with intellectual disability, Ireland has paid little attention to the prevalence of aggressive behaviours experienced by Registered Intellectual Disability Nurses (RNID). Within services the focus is mainly on intervention and management of such behaviours. Therefore a disparity occurs in that these interventions and management strategies have become the exclusive concern. Resulting in aggressive behaviour being seen as a sole entity, where similar interventions and management strategies are used for ambiguously contrasting aggressive behaviours. Consequently the ability to document and assess-specific behaviour typologies and their prevalence is fundamental not only to understand these behaviour types but also to orient and educate RNIDs in specific behaviour programme development. The paper aims to discuss these issues.

Design/methodology/approach – This study reports on a survey of the prevalence of verbal aggression, aggression against property and aggression against others experienced by RNIDs' within four residential settings across two health service executive regions in Ireland. A purposeful non-random convenience sampling method was employed. In total, 119 RNIDs responded to the survey which was an adaptation of Crocker et al. (2006) survey instrument Modified Overt Aggression Scale.

Findings – The findings of this study showed the experienced prevalence rate of verbal aggression, aggression against property and aggression against others were 64, 48.9 and 50.7 per cent, respectively. Cross-tabulation of specific correlates identifies those with a mild and intellectual disability as displaying a greater prevalence of verbal aggression and aggression against property. While those with a moderate intellectual disability displayed a higher prevalence of aggression against others. Males were reported as more aggressive across all three typologies studied and those aged between 20 and 39 recorded the highest prevalence of aggression across all three typologies. The practice classification areas of challenging behaviour and low support reported the highest prevalence of aggression within all typologies.

Originality/value – The health care of the person with intellectual disability and aggressive behaviour presents an enormous challenge for services. In-order to improve considerably the quality of life for clients, services need to take a careful considered pragmatic view of the issues for the person with intellectual disability and aggressive behaviour and develop realistic, proactive and responsive strategies. To do this, precise knowledge of the prevalence of aggressive behaviours needs to be obtained. This study is the first of its kind in the Republic of Ireland.

Keywords: Mental health, Ireland, Aggression, Challenging behaviour, Intellectual disability, Prevalence

Introduction

Traditionally addressing aggressive behaviours focused on behaviour modification techniques but this became seen as serving to address behaviours in isolation (Johnny et al., 2008). In today's healthcare environment aggressive behaviour has become seen as a complicated social pattern where ordinary life models have become increasingly emphasised within policies on the provision of services to people with intellectual disabilities (Clements, 2001). With this realisation began a focus on the social function of aggressive behaviour and emphasis on understanding the reasons for a particular behaviour as central to treatment. However, within practice the focus for service providers often remains on intervention and management strategies where aggressive behaviour is seen as a sole entity with similar intervention plans and management strategies used for clearly contrasting aggressive behaviours (Feldman et al., 2004). Therefore the capacity to document and assess the prevalence and typologies along with the severity of aggressive behaviour is critical, not only to better understand the correlates of various types of aggressive behaviours but also to orient intervention programmes whether they be prevention, assessment, monitoring or management of aggressive behaviour (Crocker et al., 2006). According to the National Intellectual Disability Database there are currently 27,324 individuals with intellectual disability living in Ireland (Kelly, 2012). However, the percentage of individuals presenting with aggressive behaviour within this group

remains unknown. Without the appropriate knowledge and understanding of the demographic attributes of the intellectual disability population regarding aggressive behaviour, intricate difficulties may arise in orientating care strategies. Therefore it is important to gain this data to assist the development and understanding of Registered Intellectual Disability Nurses (RNID's) working with people displaying aggressive behaviour and inform local policy through the identification of its population and their specific needs (Ryan and McGuire, 2006). This study will examine the experienced prevalence of three forms of aggressive behaviour – verbal aggression – aggression against others – and aggression against property.

Literature review

Aggressive behaviour within intellectual disability populations has been widely researched (Wisely et al., 2002; Collins and Cornish, 2002; McClintock et al., 2003; Slevin, 2003; Margari et al., 2005; Lowe et al., 2007; Hassiotis et al., 2008) and is considered to be the main impediment to social integration for this specific population (Crocker et al., 2006). However, barriers exist that impede staff implementing effective behavioural interventions such as the absence of an organisational ethos supporting behaviour supports (Ager and O'May, 2001), the absence of adequate performance management systems for the implementation of behavioural interventions (Reid et al., 2005), negative staff perceptions of aggressive behaviour and behavioural interventions (Ager and O'May, 2001), and the lack of consistency in classifying aggressive behaviour achieved through specific prevalence rates (Crocker et al., 2007). The latter of these barriers is particularly relevant in Ireland where few studies exist that identify the prevalence of specific aggressive behaviours. The extent of Irish literature enveloping aggressive behaviour and intellectual disability is mainly focused on comprehensive analysis of interventions, management strategies and assessment of challenging behaviour as a sole entity (Lawlor, 1999; McClean et al., 2005, 2007). However, a small number of unpublished Irish studies and reports do articulate on the specific prevalence of aggressive and challenging behaviour (Walsh and Phillips, 1995; Connolly et al., 1995; Mulrooney et al., 1997; Desmond et al., 2000). However, in a review of these studies The National Disability Authority (2002) promulgate that the prevalence rates of individuals with intellectual disability and aggressive behaviour vary infinitely in Ireland. In the absence of such evidence there is a failure to identify specific behaviour typologies and appropriate supportive strategies for both clients and staff.

Method

This study examined the experienced prevalence of specific aggressive behaviours within four intellectual disability residential settings across two health service executive regions in Ireland. A purposeful non-random convenience sample was chosen which reflected the sensitivity and nature of the study in respect to gaining access to information regarding those with intellectual disability in Ireland. One governing ethics committee granted approval for all four areas thus affording the study to ascertain a high volume of potential respondents. An information pack containing the relevant information regarding the key concepts necessary to partake in the study together with an invitation letter was distributed via their directors of nursing to RNIDs across the four areas (n=370). This enabled each respondent to fully understand the components and key requisites of the study and to give consent to partake in the study by completing and returning the questionnaire anonymously. In total, 119 questionnaires were returned completed (32 per cent response rate). The research instrument, an adaptation of Crocker et al. (2006) Modified Overt Aggression Scale (MOAS) was developed by the researchers. Permission was sought and given to use and modify the MOAS for this study. The instrument incorporated questions to ascertain the prevalence of the experienced aggressive behaviour and descriptive questions. Demographic data and ten key statements of aggressive behaviour pertaining to each of the three forms of aggression were gathered. Each key statement increased in aggressive severity through ascending order and respondents confirmed or refuted whether they experienced the specific form of aggressive behaviour. Statistical analysis was conducted using Statistical Package for the Social Sciences (SPSS version 18) developed by Norus'is (1993) to convey a comprehensive percentile of the experienced prevalence of aggressive behaviour. Data were also analysed to interpret and convey the demographic details, identify relationships between aggressive behaviour and its' correlates such as age, gender, functioning level of intellectual disability and classification of practice area. The descriptive aspect of the survey was analysed through thematic analysis and identified any correlations between responses provided and then weighted their significance to highlight themes. Cohen's k coefficient reliability (Cohen, 1960) yielded a result of substantial reliability (k=0.69) for inter-rater agreement on categorical items within the questionnaire. Cronbach's a scores above 0.7 were recorded for each section

(verbal aggression 0.884, aggression against others 0.879 and aggression against property 0.861). Content validity was undertaken through the use of an expert panel consisting of academic (n=2) and research experts (n=2) and clinical practice experts (n=2) in the areas of behaviour therapy and clinical nurse specialist (CNS).

Findings

The sample comprised of 106 females (89.1 per cent) and 13 males (10.9 per cent) which is representative of the RNID population in Ireland, where 10.6 per cent are male (An Bord Altranais, 2010). Respondents were aged between 21 and 60 years with their years' experience as an RNID ranged from 49.6 per cent (n=59) who had one to ten years, 32.8 per cent (n=39) had ten to 20 years and 17.6 per cent (n=21) had 20+ years experience. 76.9 per cent of males (n=10) worked in the practice area classified as challenging behaviour, 15.4 per cent (n=2) working in care of the elderly and 7.7 per cent (n=1) in low-support unit. For female nurses 36.7 per cent (n=39) worked in challenging behaviour, 26.3 per cent (n=30) in care of the elderly, 15 per cent (n=16) in high-dependency units, 13.2 per cent (n=14) in care of the adult, 5.6 per cent (n=6) in care of the child and 3.2 per cent (n=4) in low-support units. Of all respondents 12.6 per cent (n=15) worked with a male population, 46.2 per cent (n=55) worked with a female population and 41.2 per cent (n=49) worked with a mixed gender client group. 41.2 per cent (n=49) of respondents worked with individuals with severe intellectual disability, 39.5 per cent (n=47) worked with individuals with a moderate intellectual disability, 10.9 per cent (n=13) worked with individuals with a mild intellectual disability and 8.4 per cent (n=10) worked with individuals with a profound intellectual disability. Therefore results may not be representative of all individuals presenting with intellectual disability and aggressive behaviour as this study was based on those working with individuals in residential services and the recent shift in Ireland to supported community services has enabled individuals to move away from residential settings. Further respondent characteristics are presented in Table I.

Table 1 Respondent characteristic

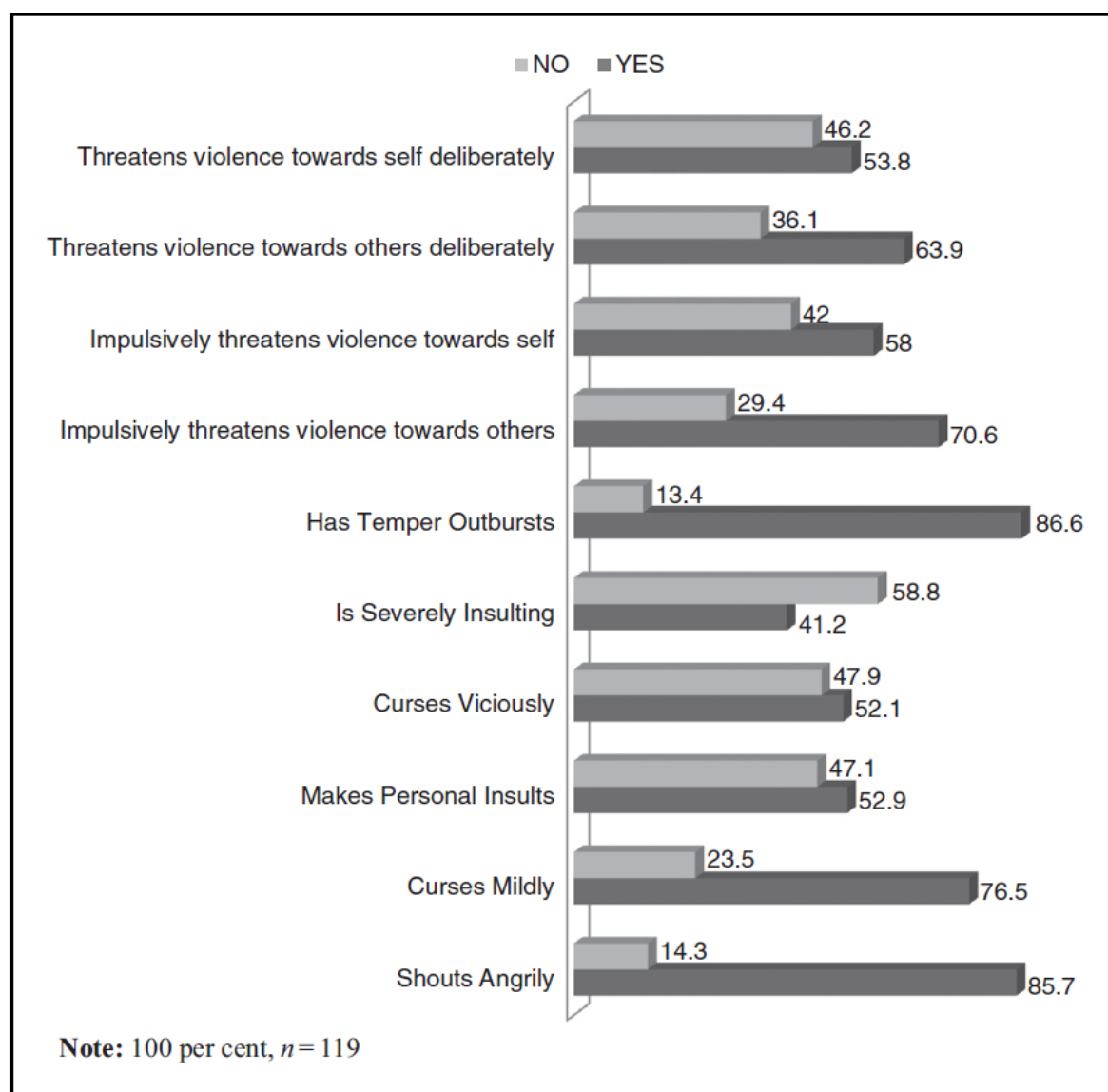
<i>Position</i>	N	%
Staff nurse	78	65.5
Clinical nurse manager 1	14	11.8
Clinical nurse manager 2	23	19.3
Clinical nurse specialist	4	3.4
<i>Qualifications</i>		
Masters	2	1.7
Post graduate diploma	18	15.1
Degree	55	46.2
Diploma	52	43.6
Certificate	20	16.9
<i>Professional qualification</i>		
RNID	102	85.7
RNID + mental health	4	3.4
RNID + general	11	9.2
RNID + sick children	2	1.7
<i>Age of client group (years)</i>		
0-12	8	6.7
13-19	9	7.6
20-39	37	31.1
40-59	35	29.4
60-79	24	20.2
80+	6	5.0

Verbal aggression

Verbal aggression was reported as the most prevalent form of aggressive behaviour experienced by RNID's with a total average experienced prevalence rate of 64 per cent. The most commonly reported form of verbal aggression experienced by RNID's was "temper outbursts" (86.6 per cent n=103) with "severely insulting language"(41.2 per cent n=49) been the least reported experienced behaviour. There was a linear

relationship between the level of intellectual disability and the prevalence of each sub group displaying verbally aggressive behaviour, individuals with a mild intellectual disability reported a higher prevalence (80.7 per cent) of verbal aggression than those functioning at the moderate level (72.1 per cent) and those with severe (55.5 per cent) and profound (47 per cent) intellectual disability, respectively. Results indicate that the higher the level of functioning, the more prevalent verbal aggression is experienced. Results found that those aged between 20 and 39 displayed a higher percentage of verbal aggression and that prevalence of verbal aggression was seen to increase with age. Figure 1 illustrates and presents the percentage variance of each form of verbal aggression. 46.2 per cent (n=55) of respondents stated that incidents of verbal aggression would not be reported if the nature of the behaviour was deemed inoffensive to staff or peers. Shouting and verbal threatening would go unreported in 51.2 per cent (n=61) of cases as the behaviour was considered to be part of the individuals personality and did not warrant reporting. The method or reporting verbal aggression highlighted in this study showed 78.9 per cent (n=94) felt that the current incident forms used for reporting aggression did not allow for the reporting of verbal aggression therefore this typology of aggression could go unreported. 26.5 per cent (n=25) suggested they would use the clients formative report sheets or daily nursing reports to report verbally aggressive behaviour.

Fig 1: Percentage prevalence of experienced verbal aggression

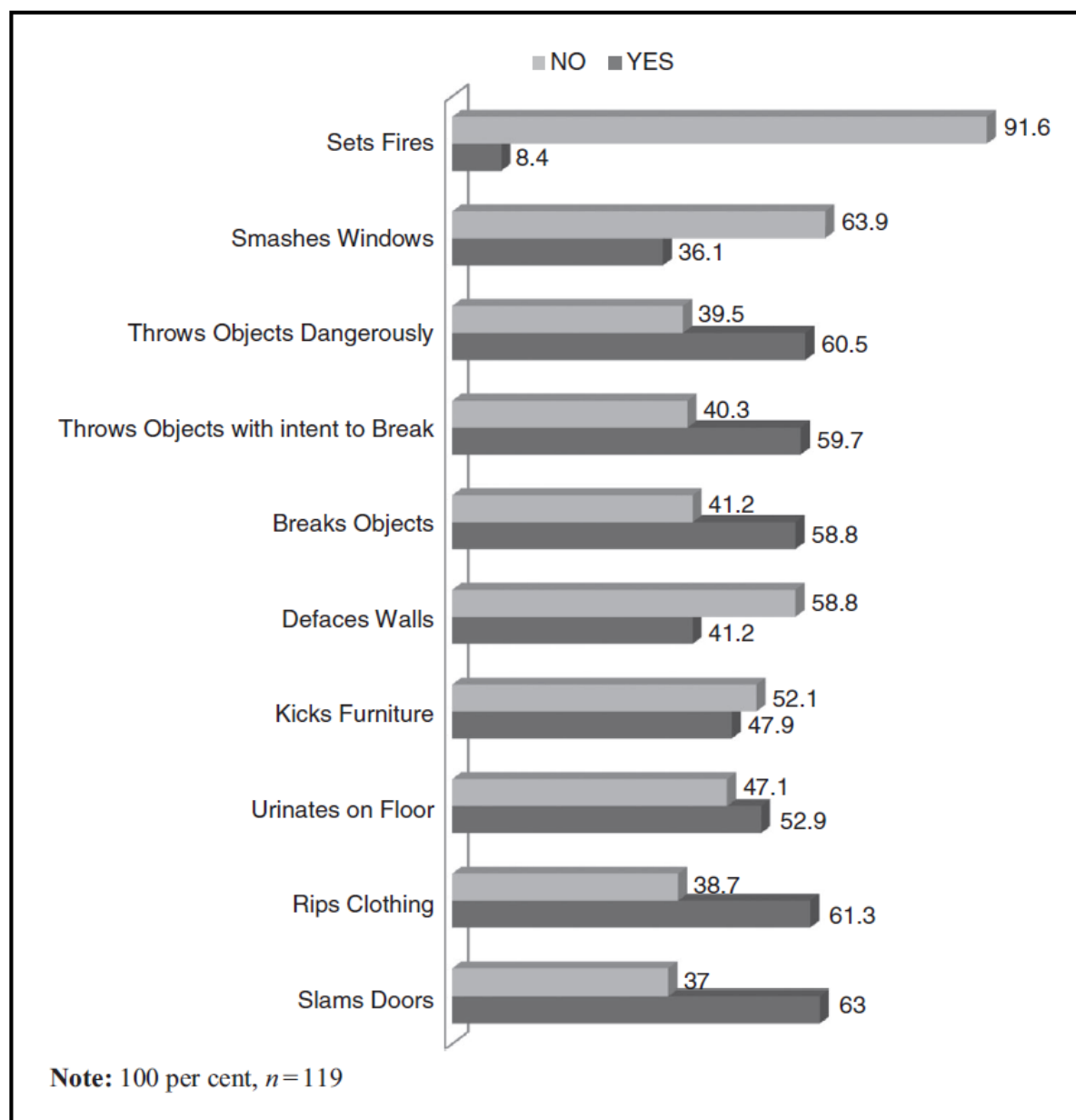


Aggression against property

Aggression against property was found to be the least prevalent of the three aggressive behaviours examined in this study with a total average experienced prevalence rate of 48.9 per cent. The most common form reported was “slamming doors” (63 per cent n=75) whereas “setting fires” (8.4 per cent n=10) was the least reported behaviour. Figure 2 illustrates and presents the percentage variance of each form of aggression

against property within the work environment. Results similarly to verbal aggression and aggression against others found that those aged between 20 and 39 displayed a higher percentage of aggression against property than any other age group. Interestingly, results show an increase of prevalence of all topographies of aggressive behaviour through the first three age categories (0-12, 13-19, 20-39) suggesting that as individuals become older prevalence of all aggressive behaviours increased. However, the three oldest age categories (40-59, 60-79 and 80+) showed a contrasting linear relationship in aggression against property, where in the prevalence of aggression against property decreased with the older population.

Fig 2: Percentage prevalence of experienced aggression against property



Aggression against property had a high rate of un-reporting with 59.6 per cent ($n=71$) stating that certain forms of aggression against property would not be reported if no physical harm was caused to anyone, if the property belonged to the individual themselves and if the items were inexpensive. 30.2 per cent ($n=36$) stated all incidents of aggression against property were reported by them. The remaining 10.2 per cent ($n=12$) did not respond.

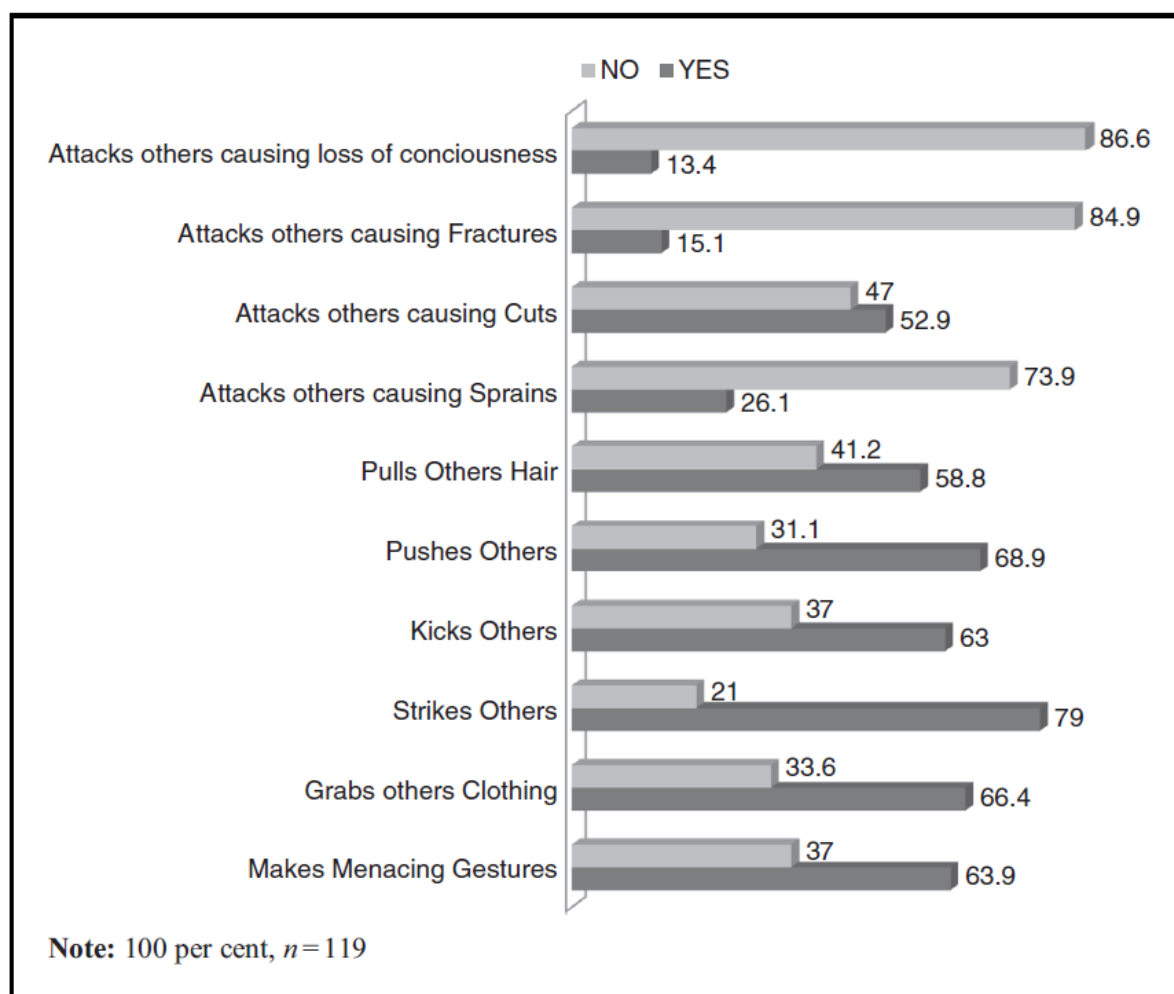
Aggression against others

An average 50.7 per cent of all RNID's surveyed experience aggression against others across the range of behaviours identified. The most common form reported was "strikes others" (79 per cent, $n=94$) with "attacks causing loss of consciousness" (13.4 per cent, $n=16$) the least reported behaviour. Due to the

seriousness of the nature of this behaviour, even low prevalence rates show that this behaviour exists and is deemed considerably dangerous and warrants further consideration. Those with a moderate intellectual disability (54.8 per cent) were revealed to engage in aggression against others comparatively more than individuals at the other functioning levels (mild-53.8, severe-50, profound-41 per cent). Those aged between 20 and 39 displayed a higher amount of aggression against others compared with the other age categories.

Levels of reporting of aggression against others were 79.8 per cent (n=95) stating all forms of aggression against others would be reported. 9.2 per cent (n=11) stated that reporting aggression against others would depend on the severity of the aggression and only major incidences which caused visible physical harm would be reported. The remaining 11 per cent (n=13) did not respond. Figure 3 illustrates and presents the percentage variance of each form of aggression against others within the work environment.

Fig 3: Percentage prevalence of experienced aggression against others



Aggressive behaviour and related correlates

There was an clear variance in the number of respondents working in each area with 41.2 per cent (n=49) working with individuals with severe intellectual disability, 39.5 per cent (n=47) worked with those with a moderate intellectual disability, 10.9 per cent (n=13) worked with individuals with a mild intellectual disability and the least prevalent group was respondents who worked with individuals with a profound intellectual disability 8.4 per cent (n=10). However, despite these obvious differences in numbers, results were analysed comparatively to obtain the correlation between aggression and level of intellectual disability. There was a linear relationship between the level of intellectual disability and the prevalence of which each sub group displayed verbally aggressive behaviour, as shown in Table II individuals with a mild intellectual disability were cited as displaying verbal aggression more than those functioning at the moderate level followed by those with severe and profound intellectual disability, respectively.

Those with a moderate intellectual disability were revealed to engage in aggression against others comparatively more than individuals at the other functioning levels, and engaged in verbal aggression and aggression against property more so than those with a severe and profound intellectual disability. The prevalence rates for those with a mild intellectual disability were also comparatively high in these categories suggesting further evidence that those with a higher functioning level may be display a higher prevalence of engaging in aggressive behaviour. However, as the number of individuals in each category were contrasting this would need to be investigated further.

There was also a significant difference in regard to the gender of the client group with whom the respondents worked, with only 12.6 per cent (n=15) working with males solely, 46.2 per cent (n=55) working with females solely and 41.2 per cent (n=49) working with a mixed gender client group. Again, results were analysed comparatively to the total number in each category to obtain the correlation between aggression and gender. Cross-tabulation of the specific forms of aggressive behaviour experienced by the respondents and the gender of the client groups with whom the respondents worked with was carried out to offer the prevalence of aggressive behaviour of each gender category.

Results showed that males with intellectual disability were more prevalent in displaying all typologies of aggressive behaviour. Respondents who worked with a mixed client group experienced a higher prevalence of aggressive behaviour than those working with females solely for the three typologies of aggressive behaviour also. Results may indicate that males show a higher prevalence of aggressive behaviour, however, as the number of individuals were not similar across all three areas this would need further investigation. Table II presents the breakdown of the typologies of aggressive behaviour correlated with the gender of the client group with whom the respondents work.

80.6 per cent (n=96) of the respondents worked with individuals between the ages of 20 and 79. 14.2 per cent (n=17) worked with individuals between 0 and 19 and 5.2 per cent worked with individuals over 80 years. Cross-tabulating the confirmed experienced aggressive behaviour across the six age categories used in this study was undertaken to obtain the correlation between age and aggressive behaviour.

Results found that those aged between 20 and 39 displayed a higher percentage of all aggressive behaviours than any other age group. Prevalence of verbal aggression was seen to increase with age whereas aggression against property and aggression against others decreased in prevalence with the older population. A total of 41.1 per cent (n=49) of respondents worked in the classification area of challenging behaviour, 25.2 per cent (n=30) and 13.5 per cent (n=16) worked in the classification area of care of the elderly and high dependency, respectively. Remaining respondents represented the remaining classification areas with 11.8 per cent (n=14) working in the area of care of the adult, 5 per cent (n=9) in care of the child and 3.4 per cent (n=4) in low support. The classification area of challenging behaviour was expected the yield the highest prevalence rates across the aggressive behaviour typologies due to the nature of this study. However, as Table II shows the highest percentage rate of aggressive behaviour occurred in the low-support areas. Nevertheless, this result may be ambiguous due to the low-response rate from RNID's working in low-support areas therefore caution should be taken in deliberating these results. Challenging behaviour areas were shown to be the next area of high prevalence of aggressive behaviour followed by care of the adult in both verbal aggression and aggression against others and care of the child in aggression against property. Across all sites the area of high dependency was shown to have the lowest prevalence of aggressive behaviour across all typologies.

Table 2: Prevalence rates and correlates of percentage variance of aggressive behaviour experienced by RNIDs'

	<i>n</i>	<i>Verbal (%)</i>	<i>Against others (%)</i>	<i>Property (%)</i>
<i>Gender</i>				
Male	15	77.3	64.0	69.3
Female	55	57.4	40.5	32.2
Mixed group	49	67.5	58.1	60.4
M % (SD)		67.4 (9.95)	54.2 (12.25)	54.3 (18.81)

<i>Age (years)</i>				
0-12	8	46.2	42.5	56.2
13-19	9	60.0	65.4	56.6
20-39	37	74.8	68.8	68.9
40-59	35	58.5	44.5	38.8
60-79	24	62.9	37.5	35.0
80+	6	65	33.3	31.2
M % (SD)		61.2 (9.34)	48.7 (14.84)	47.8 (14.92)
<i>Intellectual disability</i>				
Mild	13	80.7	53.8	56.9
Moderate	47	72.1	54.8	52.3
Severe	49	55.5	50.0	44.0
Profound	8	47.0	41.0	47.0
		63.8 (15.34)	49.9 (6.28)	50.1 (5.71)
<i>Classification of area</i>				
Challenging behaviour	49	75.3	66.1	60.6
Low support	4	85.0	75.0	70.0
Care of the elderly	30	61.6	34.6	30.0
Care of the child	6	36.6	34.6	51.6
Care of the adult	14	68.5	53.5	45.1
High dependency	16	35.6	30.6	19.3
M % (SD)		60.4 (20.37)	49.4 (18.37)	46.1 (18.92)

Discussion

The aim of this study was to report and identify the prevalence of specific typologies of aggressive behaviour reported by RNIDs' within a residential service for individuals presenting with intellectual disability. The study focused on the prevalence of verbal aggression, aggression against property and aggression against others and found the prevalence to be 64, 48.9 and 50.7 per cent, respectively. The participants in this study were solely from residential settings therefore one should be careful when generalising these results to include all individuals with intellectual disability and aggressive behaviour. Borthwick-Duffy et al. (1997) suggest that living environment and the prevalence of challenging behaviour are related. The results from this study also show that those presenting with a mild intellectual disability display a greater prevalence of verbal aggression and aggression against property. Again, generalisation of this should be carefully considered as the number of individuals within these services working with those with a mild intellectual disability was smaller than their counterparts.

This study used and augmented conceptualised key statements in describing what characterised each type of aggression to elicit an experienced prevalence rate. Verbal aggression was cited in this study as being the most prevalent form of aggressive behaviour experienced by RNID's with findings indicating a 64 per cent prevalence rate. In light of other research this study's' findings appear considerably high in comparison. However, sample characteristics between the researchers' study and other research contrast immensely with this study obtaining results from the specialised practitioner (RNID's) and other studies acquiring results from carers working with individuals who displayed verbal aggression. Research has shown that RNID's have specialised training, empirical knowledge and skills in the area of intellectual disability and aggressive behaviour (The National Council for the Professional Development of Nursing and Midwifery, 2003) therefore utilising this sample may have afforded more valid results. As verbal aggression is also conditional on personal subjectivity, cultural beliefs and intrinsic predisposition (Pejic, 2005) comparison of elemental findings between studies with different respondents from different cultures and with different inherent beliefs can be intricate. Results indicated that the higher the level of functioning of those with intellectual disability the more prevalent verbal aggression is experienced.

Aggression against property was found to be the least prevalent of the three aggressive behaviours examined in this study with a total average experienced prevalence rate of 48.9 per cent. This result appears to be similar with other studies seeking the prevalence of destruction of property or environmental aggression (Johnny et al., 2008; Tenneij and Koot, 2008). Elemental differences were found between the researchers' study and the study undertaken by Johnny et al. (2008). The researchers' study defined aggression against property as specific key statements regarding

property damage, whereas Johnny et al. (2008) used different determining factors of aggression against property, such as throwing objects at others and aggression towards others using an item. As these defining factors were exclusively diverse, true comparison in prevalence rates could not be made. However, Johnny et al. (2008) did focus on individuals with autistic spectrum conditions (ASC) and intellectual disability and those solely with intellectual disability to ascertain the prevalence, this could account for the similar results between studies. It is well documented that those with ASC and intellectual disability present with more challenging behaviours than those with intellectual disability alone (Matson and Nebel-Schwalm, 2007). Utilising associated conditions in obtaining a prevalence rate of aggressive behaviour could further develop research in this area to orient-specific interventions plans.

Prevalence of aggression against others across the study sites found that 50.7 per cent of all RNID's surveyed experience aggression against others. Those with a moderate intellectual disability were revealed to engage in aggression against others comparatively more than individuals at the other functioning levels and results indicated that younger males show a higher prevalence of aggression against others, however, as the gender number of individuals were not the same across all three areas this would need further investigation. Comparative consistency can be seen between this study and a study undertaken by Tyrer et al. (2006) where it was found that men and younger individuals appeared to be significantly more aggressive towards others. However, Tyrer et al. (2006) reported that individuals with severe intellectual disability had a substantially higher prevalence of aggression towards others. In contrast, a relationship between level of intellectual disability and aggression against others has not always been found (Deb et al., 2001) and an opposite relationship was found by Emerson et al. (2001a, b) where aggression against others was shown to occur more prominently in individuals with greater expressive skills, inferring milder levels of intellectual disability as found in this study.

More contemporary research (Crocker et al., 2006) agrees with this ethos regarding level of intellectual disability but negates that there are gender differences in physical aggression towards others. While Lowe et al. (2007) deduced that there was veracity in articulating that aggression against others was more prevalent in younger males and level of intellectual disability had no prominent significance. Comparability of elemental correlations of studies focusing on aggression against others can be intricate. Numerous research studies have found contrasting prevalence rates of aggression against others (Tyrer et al., 2006 – 14 per cent; Crocker et al., 2006 – 25 per cent; Lowe et al., 2007 – 56 per cent). McClintock et al. (2003) agreed with this after conducting a meta-analysis which combined the results of several studies that addressed the prevalence and correlates of aggression against others. This meta-analysis construed that it was extremely arduous to make comparisons between studies to formulate a median prevalence of aggression against others due to the variances of methodologically studies. However, McClintock et al. (2003) did find that males were significantly more likely to show aggression against others than females, as this study did.

Results from this study found that those aged between 20 and 39 displayed a higher percentage of all types of aggression compared with the other age categories. Interestingly, results showed an increasing rate of prevalence of all types of aggressive behaviour through the first three age categories (0-12, 13-19, 20-39) suggesting that as individuals become older prevalence of all aggressive behaviours increased. However, the three oldest age categories (40-59, 60-79 and 80+) showed a contrasting linear relationship in two types of aggressive behaviour showing that aggression against others and property decrease in prevalence as the individual gets older but the prevalence of verbal aggression was seen to increase with age. This may help educate RNID's and aid in aligning specific intervention and management strategies for those different age groups.

The concept of under-reporting was very apparent in this study. RNID's expressed a fear of unfair response and attitude towards individuals presenting with intellectual disability who displayed the aggressive behaviour. A fear of personal failure in managing the aggressive behaviour and lack of appropriate reporting procedures for milder incidents was also noted. Lyall et al. (1995) showed that personal feelings in regard to the aggressive behaviour influences emotional responses to the specific behaviour causing the incident to become a "once off", "never happen again" and "part of the job" incident, thus promoting optimism that the behaviour will not reoccur, leading to incidents of "milder" forms of aggression not being reported. This trend can be seen in this study where 46.2 per cent of respondents stated that incidents of verbal aggression

would not be reported if the nature of the behaviour was deemed inoffensive to staff or peers. Aggression against property had a high rate of un-reporting with 59.6 per cent (n=71) stating that certain forms of aggression against property would not be reported if no physical harm was caused to anyone, if the property belonged to the individual themselves and if the items were inexpensive. Aggression against others was significantly reported more often by RNIDs', however, 9.2 per cent (n=11) stated that reporting aggression against others would depend on the severity of the aggression and only major incidences which caused visible physical harm would be reported. In light of these findings, under-reporting is a cause of concern and future research should address the influencing factors of under-reporting on intervention and management of aggressive behaviour.

Within the descriptive aspect of the survey, the researcher analysed each answer and established any correlations between participants' responses and weighted their significance to highlight themes. These themes were then analysed through cross-tabulation with the preceding demographic statistical data to sequentially accentuate any commonalities in the participants' responses. Regarding the method of reporting and the overall lack of reporting of aggression was highlighted in this study as 78.9 per cent (n=94) felt that the current incident forms used for reporting aggression did not allow for the reporting of verbal aggression therefore this typology of aggression could go unreported. 26.5 per cent (n=25) suggested they would use their clients formative report sheets or daily nursing reports to report verbally aggressive behaviour:

I do consider it necessary to report verbal aggression however the current incident forms do not allow for this and focus on physical forms of aggression therefore yes it does go unreported. Verbal aggression occurs every day on the unit, as it does not cause physical harm to anybody then it shouldn't be reported. Its all about the clients personality whether they do or don't and they shouldn't be reported for expressing their personality.

Reporting verbal aggression would serve only to add to the nurses work load as referrals would have to be made if the MDT was informed of how much verbal aggression us nurses deal with every day, it can be managed at unit level.

Similarly aggression against property had a high rate of un-reporting with 59.6 per cent (n=71) stating that certain forms of aggression against property would not be reported if no physical harm was caused to anyone, if the property belonged to the individual themselves and if the items were inexpensive. 30.2 per cent (n=36) stated all incidents of aggression against property were reported by them. The remaining 10.2 per cent (n=12) did not respond:

I would not report an incident of property damage for say inexpensive items that the clients owned, if it was a TV or say an item of furniture then it would be different.

Unless the aggression caused physical harm to the person or a fellow peer or staff I don't think its necessary to report, clients break things every day, half the time it's just an accident.

Those with higher educational qualifications (degree and upwards) focused on further development of the RNID in supporting individuals presenting with intellectual disability and aggressive behaviour, through augmenting education and knowledge of the specific area of aggressive behaviour (55.4 per cent; n=66). While those with lesser educational qualifications mainly focused on increasing staffing levels, especially increasing the number of RNID's and the introduction of experienced staff to work with individuals presenting with aggressive behaviour (30.3 per cent; n=36).

Almost the entire numbers of respondents were agreeable in regard to the development of the role of CNS in challenging behaviour and articulated the need for more positions in this area.

38.6 per cent (n=46) articulated that the CNS role played an integral part in assisting RNID's to support and manage individuals with aggressive behaviour, implying that they had access to and worked in conjunction with a CNS in challenging behaviour. While 58.8 per cent (n=70) implied that the post of CNS in challenging behaviour was warranted in their services to help support RNID's in managing aggressive behaviour, in developing and implementing behaviour interventions. In essence 97.4 per cent (n=116) suggested that a CNS in challenging behaviour either did or would facilitate RNID's in working with and supporting individuals with aggressive behaviour.

89.1 per cent (n=106) of respondents also identified behavioural plans as the core to working with persons who display aggressive behaviour, and articulated the need for future development of the role of the RNID in regard to these plans. In essence, participants suggested that the RNID be the core discipline to contribute to and develop specific behavioural plans in conjunction with multi-disciplinary support rather than other disciplines; who did not work directly with the individuals concerned; deciding the content and procedures of behavioural support plans:

There is support through the use of the MDT but very little input from RNID's is considered, decision making left to the MDT. Not having full support of the MDT; as we are the frontline staff and have to use policies and guidelines laid out by the MDT.

Further education in developing protocols and guidelines to manage aggressive behaviour. The role of the RNID is being diluted by other professions who do not directly work with the clients. RNID traditionally developed and implemented protocols and guidelines at unit level.

Further recognition of RNID's unique role in the care of people with intellectual disability and aggressive behaviour is required.

In regard to specific aggressive behaviour training attained by the participants this study found that 67.2 per cent (n=80) had received specific training to support individuals presenting with intellectual disability and aggressive behaviour. In-service training in the area of Therapeutic Management of Aggression and Violence (TMAV) was the primary source of aggressive behaviour training completed by the participants (n=69), while the remaining 9.2 per cent (n=11) received specific educational training in regard to aggressive behaviour such as behavioural therapy (n=3), specific educational courses on autism and aggression (n=5) and applied behaviour analysis (n=3).

32.8 per cent (n=39) of the sample either received no specific training in aggressive behaviour or omitted this information from the survey. However, it was found that the average time since any TMAV or other form of specific training was carried out was two to three years for those working in the study sites. TMAV training was considered to be "not sufficient enough" by 49.5 per cent (n=56) in the management of aggressive behaviour. It was recognised as an important aspect of managing aggressive behaviour in the areas of de-escalation and diversional techniques and it assisted to encourage confidence, knowledge of aggressive behaviour, and willingness to respond to incidents of aggression and was beneficial in preventing injury to both the service user and staff. However, participants advocated that further education and training would be necessary in the area of aggressive behaviour to assist in the understanding of the manifestations of specific behaviours and other forms of management of aggressive behaviour should also be afforded to front line staff:

All staff need to understand the underlying causes of aggressive behaviours and to be aware that this may be the only way for the person with intellectual disability to cope, we need help to identify the reasons and coping skills of the person involved.

Aggression does not occur in a vacuum, its' usually a response to something. For someone who cannot express their fears and upset logically and calmly. Therefore I stress the importance of further training in aggressive behaviour/autism/dementia/OCD etc. Rather than just using TMAV to respond to an incident.

Conclusion

The care of the person with intellectual disability and aggressive behaviour presents an enormous challenge for services. In order to improve considerably the quality of life for clients, services need to take a carefully considered pragmatic view of the issues for the person with intellectual disability and aggressive behaviour and develop realistic, proactive and responsive strategies. To do this, precise knowledge of the prevalence of aggressive behaviours needs to be obtained. However, this is only achievable if RNID's are enabled to take a leadership role and provide direction for new strategies (Matthews, 2002) especially in the area of aggressive behaviour. Barriers that impede RNIDs in implementing effective behavioural interventions are well documented. These include the absence of an organisational ethos supporting behaviour supports (Ager

and O'May, 2001), the absence of adequate performance management systems for the implementation of behavioural interventions (Reid et al., 2005), negative staff perceptions of aggressive behaviour and behavioural interventions (Ager and O'May, 2001), and the lack of consistency in classifying aggressive behaviour achieved through specific prevalence rates (Crocker et al., 2007). The latter of these barriers is particularly relevant in Ireland where there is a paucity of studies carried out to identify the prevalence of aggressive behaviours. The findings of this study showed the experienced prevalence rate of verbal aggression, aggression against property and aggression against others were 64, 48.9 and 50.7 per cent, respectively.

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